# THE USE OF PSYCHOTHERAPY FOR SERIOUSLY DISTURBED PATIENTS*

W. K. McKNIGHT

The New York Hospital, Westchester Division

IN previous communications having to do with the concept of the treatment of mental illness within a hospital environment which is planned as a cultural pattern of therapeutic significance by Wall, Hamilton and others,[1-3] the various component parts of such a treatment program have been described. A further review of the extensive literature having to do with the scope and methods of psychotherapy[4-6] is indicative of the many ways in which various therapists have attempted to influence the course of emotional illness in their patients. In the present study, reference will be made to the application of some of the principles of psychotherapy, the validity of which has come to be understood by clinical research and practice as they are employed in the setting of a modern psychiatric hospital, that of the New York Hospital, Westchester Division.

In recent years it has been possible to begin an overall evaluation of our experiences in the development of psychotherapeutic techniques with some degree of perspective together with an increasing objectivity frequently not possible during the course and enthusiasm of developing insight, self-expression and initial accomplishments untempered by accurate self-criticism and comparative study. Various writers[7-9] have helped in this way by tracing and examining the historical growth of our understanding of the human individual in relation to his environment and changing cultural patterns and of his basic personality qualities with which he makes or fails to make an adequate adjustment to the society in which he lives. Such studies indicate that, while much has been gained in identifying rational methods of treatment, the need continues for further research and experience in application.

The urgency for new definitions of individual and social goals being

* Presented at a combined meeting of the Section on Neurology and Psychiatry and the New York Neurological Society, at The New York Academy of Medicine, January 12, 1954.
Manuscript received January 1954.

forced upon society by growth and development in the physical sciences[10] is being felt by scholars and laymen alike as atomic and other scientific research outstrips social improvement and offers the choice of unlimited destruction[11, 12] or more complete understanding in the matter of human endeavor. The practice of psychiatry and of psychotherapy is today inextricably a part of this problem and an active role is being taken by them in the direction of attaining a concept of health and philosophy that will reflect our best ability to understand ourselves and others, or as Hocking[13] has phrased it, of "What man can make of man." Maturity of the human personality must be gauged in the final analysis not solely in terms of freedom from crippling anxiety and fear but by the achievement of a sense of personal and social values which is compatible with the basic biologic characteristics of the individual.

Sir Russell Brain[14] in giving the recent Annual Oration for the Medical Society of London chose as his subject: "The Need for a Philosophy of Medicine," and he said, "we speak of medicine as both a science and an art, and surely these two aspects are complementary. Science is analytic, explaining or seeking to explain, the whole in terms of the part; art is intuitive, and sees in the whole something more than can be explained as the sum of its parts." In considering that "medicine alone takes as its province the whole man," he reminds us that this has been the traditional quality of medicine, and we realize that it should continue to be the basis upon which medicine should relate itself to the individual patient and to society. The methods by which the therapist through his personality applies the theories and products of scientific research constitutes the art of medicine and as such becomes the definitive, motivating force of psychotherapy.

In looking back briefly over the past an appraisal of some of the more significant steps in the understanding of the psychotherapeutic process will make more tangible the objectives of therapy in relation to the causes and nature of symptoms as we have come to recognize and interpret them. Throughout history man has been preoccupied with trying to understand himself in relation to the universe and the infinite, while at the same time he has been engaged in the struggle to survive in the physical sense against many threatening forces. Failing in the latter aspiration, much of his life experience has been concerned with his efforts to substitute an idealistic immortality for a physical one, and the intelligence which distinguishes him primarily from the other mammals has

enabled him to accumulate a store of knowledge with which he has been able to discriminate between fact and fancy. He has also by this means been able to modify and control his environment to his advantage, and his ability to communicate through language has obligated him to a type of responsibility in social living not shared by any other species. Attempts to solve the riddle of death and of beginning life as related to the function of the instinct for survival constitute the earliest concepts of magic and religion, and no prehistoric culture has been discovered that does not give evidence of protective measures finding expression in religious rituals, totems and taboos.[15, 16] Eventually the conflicts arising from the need for instinctual satisfactions and the relationships of pain and pleasure[17] as basic mechanisms in an increasingly complicated social order gave rise to conditioned patterns of behavior often at variance with the established order of living. This in turn led to his experiencing the effects of fearfulness which he was either not able or not permitted to recognize as such or to express in direct or effective ways. Anxieties thus engendered became the source of feeling, thinking and behavior which we identify as symptoms of mental illness. To be no longer an animal unable to speculate as to his future but rather to have become the twentieth century civilized man that we credit ourselves with being today has meant the slow traversing of many stages and types of cultural experimentation in which the human personality has many times been victimized by its failures. In spite of this, however, man has demonstrated a continued resilient adaptive capacity to gain understanding and insight from which one can justifiably derive a sense of reassurance and optimism.

From a clinical psychiatric standpoint the beginning of a scientific formulation of the application of psychotherapeutic principles began some years after the first experiments with hypnotism when, during the American Civil War period (1860-70), the English physician, James Braid, and the French practitioner, A. A. Liebeault, began to test in an objectively unbiased way the observed effects of psychological reactions on the physical organism. Zilboorg[18] thus states in his historical review that "the birth of psychotherapy through Braid and Liebeault was a unique event in medical history." With the subsequent quickening of the psychological pulse through the research of Freud and the psychoanalytic technique, the significance of cause and effect became more apparent and accessible to analysis, though not without much heated

controversy, and there followed a phenomenally rapid increase in the usefulness of psychotherapy during the past forty years of medical progress. The roster of therapists who have pioneered in seeking methods of applying dynamic insight in the treatment of patients continues to grow[5, 7, 18, 19] and from such efforts psychotherapy is becoming more specific in the practical sense and more capable of being tailored to suit the patient's individual needs.[11, 20-28]

In the present study a review of some twenty cases was made in which psychotherapeutic techniques were used in relation to other aspects of hospital treatment with emphasis being placed on helping the patient to center his attention on the reality of his situation and of remotivating himself toward dealing with his problems and symptoms in positive, aggressively constructive ways. This is, accordingly, an attempt to communicate individual experience in psychotherapy, which is, of course difficult to express with complete objectivity or with the aid of statistics. In so far as it is possible to judge, improvement seemed to be related to the mechanisms described.

For the patient who can most benefit by hospital care, the combination of good physical care, nursing attention and medical treatment with psychotherapy provides the best opportunity for clinical response. Playing the role of the "good parent" it is necessary to remember that as O'Neil[29] says, "the physical health of an individual is important in itself" and that "physical symptoms or injuries are not always mere expressions of inner conflict." Attitudes of the patient toward actual physical illness which is limiting or painful may then be modified gradually as reaction patterns become known. Eventually, as the patient becomes more responsive and less fearful it is important to help him recall or perhaps realize for the first time the various roles[30] in which the therapist has functioned and to compare them with the ways in which other persons such as physicians, teachers, friends, parents, ministers, employers, and other associates in reality can help him in ways that are unique to their positions. Reorientations of this nature are of value in helping the patient begin to resolve his fears, hostilities, guilt and defensive behavior.

One of the present group of patients expressed great concern and perplexity relative to his previous treatment which had followed formal analytic lines, and he was frightened and resentful that he could still be incapacitated by an impulse to jump to his destruction which he

could scarcely control until his hospital admission. His course in therapy is suggestive of several of the therapeutic methods now being considered.

Mr. L., age thirty-two and single was the second of two sons born to intelligent, well educated parents who, however, were poorly adjusted within themselves and to each other so that the family life was a most disturbed one during his early years. The father, meticulous and overly conscientious, was forced into marriage by the occurrence of a pregnancy. The mother was unable to accept the feminine role in life and tried by all means at her command to discredit men generally and the members of her own family in particular. Assailed by guilt over her conscious rejection of her sons, she would then become oversolicitous of and seductive to them until she would again become absorbed in an extra-marital affair or in her teaching and civic work. Both the patient and his brother felt very much left to their own devices, although they developed a close emotional attachment to one of a series of governesses. It happened, too, that the older brother tried on three separate occasions to destroy the patient before he was five years old; once by releasing his baby carriage, once by pushing him into the water, and once by pushing him out of an upper barn window from which his fall was broken by a pile of manure. During his school years the patient made what appeared to be a reasonably effective social adjustment, and his superior intelligence made scholastic progress relatively easy with special achievements in creative writing. During several years of military service he found himself in conflict in regard to his sexuality because of masturbatory guilt, lack of confidence in his relationships with girls, and some homosexual experimentations. Shortly after his military separation he began to have severe nocturnal anxiety attacks for which he eventually sought psychiatric help, and for two years he received therapy with improvement. However, in attempting to work as a publishing journal editor he became panicky, left his job, and then felt the almost irresistible urge to jump from his eighth-floor window.

During his present hospital period he has been able to verbalize his preoccupations and feelings of depersonalization which had prevented him from participating realistically in his previous treatment, since he could tolerate his association with his physician only as long as he could believe that he was "a third person" looking on without actually becoming involved. He felt that he had been rejected by his parents and that he had been hostile in his reactions to breast-feeding and to toilet train-

ing. Believing also that he had bitterly resented the "punitive, unrewarding attitude" of his elders relating to his early bowel control experience, the act of defecation became to him a "giving of himself" which he eventually associated with doing work of any kind, so that no amount of monetary remuneration was sufficient to justify or reward his best efforts. In addition, it became safe only to be "passive" and he developed the phantasy-conviction that if he "appeased" and appeared to be "dumb and unresponsive," he could not only hope to avoid "destruction" but also, in a measure, gain a defensive upper-hand in his relations with others. Consequently, he devised a world of his own thought in which he remained detached and aloof from others, feeling "secure" in the delusion that he was "omnipotent" and that he could ignore, accept or control the behavior of others at will and indeed, as he said, "destroy them by simply lifting a finger" if he chose. Anxiety and rage reactions developed when he could not actually control his associates nor compete successfully with them, and he took refuge in the mechanism of either sabotaging his own accomplishments or of leaving them unfinished. The world to him became a giant "womb" and he became preoccupied with thoughts of "deep, dark depths of water" which were both fascinating and terrorizing to him. Fearfully competing with his brother during childhood while at the same time admiring him, he felt that his impulse to jump from a high level was a repetition of his desire to "identify with" his brother and he suspected that there "might also be an element of sexual attraction in this reaction."

Admittedly fearful following his admission, he was nevertheless articulate, and in responding to the initial contact with the therapist, it was apparent that he was a sensitive person of refinement and social standing. Physical examination was within normal limits and a beginning rapport was carefully sought by permitting and encouraging him to express his immediate concerns and reactions to having come to the hospital. These had to do with the nature of the hospital program and particularly with the schedule and frequency with which "psychotherapy" interviews would be planned which he expected to be his greatest source of help. This reflected his previous experience in analytic therapy, and he later described his fear of not being "seen frequently enough," since in the beginning, he saw this as his only means of "controlling" the situation and protecting himself from being influenced against his will. He expressed relief, however, at being in the security

of the hospital but he asked for reassurance as to being protected from doing some impulsive harm to himself or others. Following a direct explanation of the nature of the hospital, its facilities and purposes in addition to a brief discussion of what would be expected of him, he became notably more at ease and able to respond to some humorous remarks as a subsequent interview time was planned. The next several interviews were devoted to some discussion of his current reactions but included also a briefly comprehensive survey of his history, personality, interests and general experiences. This information, being elicited in an orderly fashion, included references to all of the phases of his life and served several purposes considered to be therapeutically important at the beginning of treatment. This procedure provides the patient with an orientation of the therapist's scope of interest and creates a beginning frame of reference as to the significance of experience and personal values. An attitude on the part of the therapist that is accepting, and desensitizing without indication of personal intensity of feeling or prejudice at this time has proved to be helpful in minimizing threat when the patient is fearful, while at the same time permitting him the use of whatever defensive measures he may feel necessary at first. Brief, tactful inquiry of this type opens the way for further discussions of conflict material, and indicates a willingness on the part of the therapist to share in a responsible way whatever the patient may consider to be of importance.[22, 23]

Detailed descriptions, or even identification of all the more subtle psychological "give and take" reactions that characterize a beginning patient-therapist relationship are difficult to record but must be deliberate in the mind of the therapist at the time in relation to his interpretation of the patient's need.[31-34] In the case of Mr. L. it developed later that he had been much relieved during the first interview to note that the therapist had managed as he said, "to sense my fear of a close contact while at the same time conveying in a respectful way his acceptance of my hostility and wretchedness."

As contacts continued briefly during the making of rounds, in passing at various activities or at greater length in scheduled interviews, Mr. L. expressed various emotional reactions relating to his experiences or symptoms and he began to use the therapist in various ways. He would attempt to dominate, to tyrannize and to seduce. He asked for direction and would then disobey. Seeking reassurance, comfort and

pampering, he tested the therapist for some indication of falseness, and he displayed the whole gamut of affective display with frequent recourse to well-intellectualized verbalizations. Efforts to invalidate the therapy process were expressed in his comparisons with his previous therapy and he was chagrined to be required to review such comparisons with more and more accuracy until he was surprised at his eventually being able to evaluate the gains that it had provided in a realistic way. Similarly, in all of his reactions he was encouraged and at times authoritatively required to measure his preoccupations and his behavior against his immediate environmental situation until he gradually began to identify a new kind of satisfaction in his experience which, as he said, was unburdened by his former pathologic anxieties in his relationships with people and even with his mother about whom much of his conflict had centered. Carefully timed and formulated discussions with the mother enabled her to participate constructively in the therapy by lessening her need to relate to the patient in unhealthy ways. Attention to small courtesies and considerations of his feelings without oversolicitation were important in convincing him of the consistency of the therapist's attitude, but little or no quarter was given to unreasonable demands or conniving duplicity as these mechanisms were uncovered and evaluated in discussion periods.

Having had little support or direction from his passive, self-centered and hypochondriacal father, he described his reluctance at first in asking for concrete suggestions but when he did, there was a lack of his former veiled defiance and he revealed a childlike naivete that presaged a significant change in his attitude. He said, "I have been discouraged lately at my wanting to be alone in my room to withhold myself from the others in a spirit of retaliation for the inconsiderateness, but at the same time I want to be with them. How can I make myself feel that they like me and that I do not have to be afraid of being hurt?" Emphasis was then placed in a suggestive way on small evidences of his growing ability to respond to reality situations and he was commended on his response to a letter of inquiry for his advice about a literary matter. In this and other ways, as much attention was paid to his over-all behavior as to his specific symptoms. He continued to revert to his need to identify the origins of his symptoms by striving for early recollections, but he began to be less concerned with the accuracy of these researches in comparison with his increasing confidence in relating more successfully with people and

with less anxiety and hostility. Eventually after about five months he began to express "a good feeling" of "being unified" and of being able to accept others without the feeling that they were about to destroy him and of translating his conviction of having omnipotent power into a new idealism having the quality of a faith. This puzzled him, since he had always considered that "God was an all powerful force" which he had identified with other threatening influences whose expectations of him were quite beyond his capacities and whose mercy would be only a temporary respite before his destruction. He described a new feeling of security reflecting an appreciation of the best qualities in others while at the same time a toleration of their hostilities and shortcomings.

This brief review of the general course of therapy for one patient has been condensed to the point of much over-simplification but it serves to illustrate some of the objectives of treatment as they were achieved by the patient-therapist relationship[35, 36] in a carefully planned environment in which the patient gradually achieved a more normal living experience.

In a second instance, Mr. D. was admitted at age forty after having had an acute psychotic break in which he experienced ideas of reference, depression and confusion. Intelligent, an accomplished concert pianist and music teacher, he became convinced that he had broken a law in failing to include the name of his school on a brochure relating to his concert work and he became panicky at having a certain book in his library which he felt was not consistent with the policies of the school in which he taught. Following admission, considerable time was spent in repetitiously orienting him as to the nature of the hospital while his confusion gradually cleared. He was also reassured daily as to his assumption that his entire life and career had been ruined by his illness. As rapport developed through his dependency and his need for reassurance, he became more relaxed in his attitude and gradually he was able to describe his experience. At first notably defensive in avoiding any expression of hostility towards his parents he eventually talked of his life-long conflict about his relations to them and his feelings of rejection by them. It was confirmed by history that they had sent him to his grandmother's for his first eight years and had favored his younger sister. They had also disapproved of his interest in music and even after his admission indicated their belief that his illness justified their attitude and could be used to change his mind about his music.

Here again this patient was able to develop a relationship with the therapist in which he could gradually be motivated and encouraged to participate in reality activities while at the same time reviewing his past adjustments with new understanding. He came to realize that he had been compulsively trying to achieve a successful perfection in his music in the mistaken belief that this would result in the acceptance by his parents that had previously been denied him and at the same time there were indications of his trying to prove himself in the masculine sense. With evidences of a changing attitude on the part of his parents, he was overly anxious to accept their new overtures for help and financial support but he was advised to wait until he had discussed the matter a number of times. Eventually he was able to plan his future with their help but without further feelings of defeated obligation and subjugation. It is thus apparent that in both cases just cited an important element in the psychotherapy was the contact by the therapist with the significant relatives in affording them the opportunity for expression and carefully planned and timed discussions of their relationships with the patients. At the same time, the patient is helped to understand the therapist's purpose in working with the relatives as being valuable in the patient's interest rather than a "taking the family's side" process.

A third case in the present series illustrates the use of similar efforts in the treatment of a severe depressive reaction with underlying long-standing compulsiveness. Mr. D. was a forty year old, competent hair-dresser of good intelligence who had completed only high-school education before it was necessary for him to become self-supporting. Never able to express either recognized or unrecognized hostilities and fears relating to his emotional dependence and his psychosexual development, he became characteristically compulsive to a moderate degree, hypochondriacal, and over a period of years suffered with neurotic fatigue states which he attributed to overwork. Relieved temporarily of a depressive episode by means of electroconvulsive treatments and again by ambulatory insulin and histamine injections when his symptoms recurred, he was admitted in a severely depressed state with a hopeless and suicidal trend. He repeated over and over his belief that he should be "put away" where he would no longer be a problem to his family, and he did not wish to see his wife whom he had not seen for two months while he visited with a sister. He expressed surprise when he was advised to see his wife but he came to realize her proper concern,

her interest, and her need to share his illness. This occurred in spite of his guilt reactions and the unconscious threat which she represented. Visiting periods were carefully planned, and interviews gradually uncovered his feelings of sexual inadequacy, although for a considerable time he would revert to his complaint that he was concerned only about his "head pressure" and his inability to sleep. After several months during which the patient was helped to participate in group activities, given support and encouraged to talk of his earlier experiences, he was able to accept the realities of his living with diminishing anxieties so that his first afternoon away from the hospital with his wife was mutually quite satisfactory. His use of the therapist as a father substitute and his assimilation of educational information, interpretations and guidance reduced his immature dependencies, and without the use of electroconvulsive treatment he was able to leave the hospital in a much improved condition with a favorable prognosis.

In the remaining seventeen cases comprising the group in this study some of the more significant measures that proved to be helpful in stimulating useful responses to reality situations included: firm resistance on the part of the therapist to demoralized denials of reality problems, reassurance as to status, gauging the response to be expected to the adaptive capacity, temporary assumption of discipline and decision-making responsibility, tactful, unthreatening temporizing with seduction and rage behavior, planned or supervised use of visiting periods for relatives, repeated identification of reality circumstances, stimulating new methods of creative expression and experience, identifying the meanings of symbolic patterns of expression and behavior, and detailed attention to the patient's individual dignity as a person.

It has been said that "specific techniques grow out of the uniquely personal way in which an individual therapist relates to his patients,"[37] and many times a therapist in training has to be guided away from his conscious or unconscious attempts to emulate in detail the ways of his preceptor or of some other therapist whose success he admires. The acquisition of knowledge, self-discipline[22] and dynamic insight must be combined with the acceptance by the therapist of his own personality and his use of it in the best interests of the patient. In this way, the more widespread application of carefully planned psychotherapeutic techniques based on the dynamic understanding of personality and psychobiological relationships which we possess today will be increasingly

effective in the amelioration of symptoms and in the promotion of preventive mental hygiene.

In summary, a consideration of several various aspects and methods of psychotherapeutic practice with seriously disturbed patients in relation to dynamically planned hospital care has been presented, emphasizing the goal of helping the patient to meet his reality circumstances to a maximum degree through psychotherapy.

*REFERENCES*


1. Hamilton, D. M. and Wall, J. H. Hospital treatment of patients with psychoneurotic disorders, *Amer. J. Psychiat. 98*:551-57, 1942.
2. Hamilton, D. M. The psychiatric hospital as a cultural pattern, in *Current therapies of personality disorders* (B. Glueck, ed.), New York, Grune & Stratton, 1946, pp. 18-35.
3. Hamilton, D. M. Cultural treatment in a psychiatric hospital, *Int. J. Group Psychother. 3*:204-09, 1953.
4. Ruggles, A. H. The place and scope of psychotherapy, viewing fifty years in psychiatry. *Salmon Memorial Lecture* (New York Academy of Medicine), 1951.
5. Rickman, J. The role and future of psychotherapy within psychiatry, *J. ment. Sci. 96*:181-89, 1950.
6. Bychowski, G. and Despert, J. L. (editors). *Specialized techniques in psychotherapy.* New York, Basic Books, 1953.
7. Gottschalk, L. A. Systematic psychotherapy of the psychoses, *Psychiat. Quart. 21*:554-74, 1947.
8. Galdston, I. Psychiatry in the history of medicine, in *Modern attitudes in psychiatry* (March of Medicine, No. 10), New York, Columbia University Press, 1946, pp. 1-28.
9. Wall, J. H. Development of modern psychiatry, in *Modern attitudes in psychiatry* (March of Medicine, No. 10), New York, Columbia University Press, 1946, pp. 29-42.
10. Wightman, W. P. D. *The growth of scientific ideas.* London, Oliver & Boyd, 1950.
11. Oberndorf, C. P. Constant elements in psychotherapy, *Psychoanal. Quart. 15:* 435-39, 1946.
12. Lecomte du Noüy, P. *Human destiny.* New York, Longmans, Green & Co., 1947.
13. Hocking, W. E. What man can make of man, *Fortune Mag.,* 1940.
14. Brain, R. The need for a philosophy of medicine, *Lancet 264*:959-64, 1953.
15. Sedillot, R. *History of the world.* New York, Harcourt, Brace & Co., 1951.
16. Smith, H. W. *Man and his gods.* Boston, Little, Brown & Co., 1953.
17. Freud, S. *General introduction to psychoanalysis.* Garden City, N. Y., Garden City Pub. Co., 1943.
18. Zilboorg, G. and Henry, G. W. *A history of medical psychology.* New York, W. W. Norton & Co., 1941.
19. Diethelm, O. *Treatment in psychiatry.* 2.ed. Springfield, Ill., C. C. Thomas, 1950.
20. Ziskind, E. How specific is psychotherapy? *Amer. J. Psychiat. 106*:285-91, 1949.
21. Kubie, L. S. The nature of psychotherapy, *Bull. N. Y. Acad. Med. 19*:183-94, 1943.
22. Coleman, J. V. Patient-physician relationship in psychotherapy, *Amer. J. Psychiat. 104*:638-41, 1948.
23. Fromm-Reichmann, F. Psychoanalytic psychotherapy with psychotics, *Psychiatry 6*:277-79, 1943.
24. Alexander, L. General principles of psychotherapy, *Amer. J. Psychiat. 106:* 721-31, 1950.
25. Appel, K. E. Psychiatric therapy, in *Personality and the behavior disorders* (J. McV. Hunt, ed.) New York, Ronald Press, 1944, v. *2,* pp. 1107-1163.

26. Levine, M. Principles of psychiatric treatment, in *Dynamic psychiatry* edited by F. Alexander and Helen Ross, Chicago, University of Chicago Press, 1952, pp. 307-366.
27. Whitehorn, J. C. Guide to interviewing and clinical personality study, *Arch. Neurol. Psychiat. 52:*197-216, 1944.
28. Finesinger, J. E. Psychiatric interviewing, *Amer. J. Psychiat. 105:*187-95, 1948.
29. O'Neil, J. F. Discussion of some problems in psychotherapy, *Proc. New York Hosp. Westchester Div.,* April 1953.
30. Sprague, G. S. The psychiatrist's rôles with his patients, *Amer. J. Psychiat. 95:* 135-47, 1938.
31. Lewin, B. D. Counter-transference in technique of medical practice, *Psychosom. Med. 8:*195-99, 1946.
32. Bartemeier, L. H. The attitude of the physician, *J. Amer. med. Assoc. 145:* 1122-25, 1951.
33. Fromm-Reichmann, F. Notes on the personal and professional requirements of a psychotherapist, *Psychiatry 12:*361-78, 1949.
34. Rosenheim, F. Basic attitudes and goals of the therapist, *Ment. Hyg. 34:*400-05, 1950.
35. Colby, K. M. *A primer for psychotherapists.* New York, Ronald Press, 1951.
36. Kraines, S. H. *The therapy of the neuroses and psychoses.* 3. ed. Philadelphia, Lea & Febiger, 1948.
37. Whitaker, C. A. and Malone, T. P. *The roots of psychotherapy,* Philadelphia, Blakiston, 1953.

## FELLOWS' PORTRAITS

It may not be generally known to Fellows of the Academy that the Library has an outstanding collection of medical portraits: some 10,200 separate ones mounted and about 139,300 catalogued in books and journals. It goes without saying that a picture of every Academy Fellow ought to be found here, and Fellows are invited to send the Library their photographs, if one is not already on file. Any size is acceptable, from the vest-pocket or cabinet photograph up; what is desirable is that it be a good likeness. Further, pictures of any other physicians for which Fellows wish to find a repository will be a welcome addition to the Library's collection.